

Local Government Health Plan Rate Tier Survey

Please complete and return to:

Local Government Health Plan
P.O. Box 10105
Springfield, Illinois 62791

General Information

Name of Unit: _____
Address: _____
City/Zip: _____
Contact Person: _____
Telephone No.: _____
Date: _____

Does unit currently provide group health
benefits to its:

	Yes	No
Employees	<input type="checkbox"/>	<input type="checkbox"/>
Annuitants	<input type="checkbox"/>	<input type="checkbox"/>
Dependents	<input type="checkbox"/>	<input type="checkbox"/>
Elec. Officials	<input type="checkbox"/>	<input type="checkbox"/>

What is the policy period or termination
date of current health coverage?

	Yes	No
Are dental benefits currently provided:	<input type="checkbox"/>	<input type="checkbox"/>
Are vision benefits currently provided:	<input type="checkbox"/>	<input type="checkbox"/>

What percentage of the premium is/will be paid by
the unit for its:

Employees	_____	%
Annuitants	_____	%
Dependents	_____	%
Elected Officials	_____	%

Instructions: Please read before completing Demographic Information (see reverse side)

1. Section I: Include the demographic information on all full-time employees, and any annuitants and/or elected officials.
2. Section II: Members who will be enrolled should be categorized as either Non-Medicare or Medicare Primary.
Of those members, indicate the number that have dependents in the listed categories. Include members in dependent categories only if the members intend to enroll those dependents.
3. Section III: Include the demographic information on dependents that you intend to enroll.
4. With specific regard to your employees please remember that at least 85% of all full-time employees must participate. Part time employees who work between 50% and 90% of the unit's normal work period may participate.
Part time employees who work less than 50% of the unit's normal work period may not participate.
5. Elected officials who receive salary or wages from the unit may also participate regardless of the number of hours worked.
6. Finally, with regard to your annuitants and survivors, please remember that each unit has the option to cover this group and if so, each annuitant/survivor would have the individual option to participate.

Demographic Information

Name of Unit: _____

Section I: Members

Age	Number of All Participating Employees & Elected Officials		Number of All Participating Annuitants/Survivors with Medicare A & B		Number of All Participating Annuitants/Survivors without Medicare A & B	
	Male	Female	Male	Female	Male	Female
0 - 24	_____	_____	_____	_____	_____	_____
25 - 29	_____	_____	_____	_____	_____	_____
30 - 34	_____	_____	_____	_____	_____	_____
35 - 39	_____	_____	_____	_____	_____	_____
40 - 44	_____	_____	_____	_____	_____	_____
45 - 49	_____	_____	_____	_____	_____	_____
50 - 54	_____	_____	_____	_____	_____	_____
55 - 59	_____	_____	_____	_____	_____	_____
60 - 64	_____	_____	_____	_____	_____	_____
65 and over	_____	_____	_____	_____	_____	_____

Section II: Member Enrollment in Dependent Plans					
	All Non-Medicare Members	Members W/1 Non-Medicare Dependent	Members W/2+ Non-Medicare Dependents	All Medicare Members	Members W/Medicare Dependents
Members	_____	_____	_____	_____	_____

Section III: Dependents

Age	Number of All Participating Employee Dependents - Adults		Number of All Participating Annuitant Dependents with Medicare A & B		Number of All Participating Annuitant Dependents without Medicare A & B	
	Male	Female	Male	Female	Male	Female
< 1	_____	_____	_____	_____	_____	_____
1 - 2	_____	_____	_____	_____	_____	_____
3 - 10	_____	_____	_____	_____	_____	_____
11 - 15	_____	_____	_____	_____	_____	_____
16 - 24	_____	_____	_____	_____	_____	_____
25 - 29	_____	_____	_____	_____	_____	_____
30 - 34	_____	_____	_____	_____	_____	_____
35 - 39	_____	_____	_____	_____	_____	_____
40 - 44	_____	_____	_____	_____	_____	_____
45 - 49	_____	_____	_____	_____	_____	_____
50 - 54	_____	_____	_____	_____	_____	_____
55 - 59	_____	_____	_____	_____	_____	_____
60 - 64	_____	_____	_____	_____	_____	_____
65 and over	_____	_____	_____	_____	_____	_____